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DRUG REVOLVING FUND: REVIVING COMMUNITY ADMINISTRATIVE STRUCTURE TO CREATE SELF-SUSTAINING PRIMARY HEALTHCARE FACILITIES IN NIGERIA

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ABSTRACT

For Nigeria as a nation to achieve universal health coverage for its citizens depends mainly on the foundational role of primary healthcare (PHC) services within the healthcare sector. By prioritising the citizens' actual medical requirements and choices among the population, the PHC healthcare model enables effective and accessible delivery in most developing countries. In developing nations like Nigeria, persistent issues such as insufficient funding, resource mismanagement, and weak oversight frequently interrupt the efficiency of the healthcare sector. In developing nations like Nigeria, persistent issues such as insufficient funding, resource mismanagement, and weak oversight frequently interrupt the efficiency of the healthcare sector. To mitigate these financial challenges and ensure the consistent availability of vital drugs, the Drug Revolving Fund (DRF) was introduced as a self-reliance health financing policy for health facilities. Furthermore, The Ward Development Committee (WDC) coordinates the steps needed to mobilize human, material resources, and finances in the community to support the PHC. The overall service quality can be easily improved by involving the community and having them take ownership of the PHC. However, the lack of a functional WDC system in most Nigerian communities has negatively impacted the functionality of the PHC due to poor community involvement. In this study, we highlighted the DRF implementations and the bottlenecks across healthcare facilities and how reviving a WDC system can help strengthen healthcare access at the primary care level.

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INTRODUCTION

Primary health care is basic health care which includes preventive, curative and health promotive activities for people living in resource-poor setting in a cost friendly way [1]. Primary health care functions within the various components of basic care and core parts of integrated service delivery,

partnership approach and granting community power to make decisions [2]. According to World Health Organization, access to health is fundamental human right [2]. But the world has not yet reached it, even after more than seven decades of committed efforts [3]. The basic principle behind primary

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care is for local community to access care in their community at no cost [4]. The essential of primary health care is for people in a community to live in sound health throughout their life span by meeting their health needs which includes prevention, treatment, healthy lifestyle education and supportive care [4]. The primary health care system, which is based on four main pillars, is essential for community development and socioeconomic equilibrium [2]. Community involvement, multi-stakeholder partnership, appropriate technologies, and support systems are the four main pillars of basic healthcare [2]. The primary healthcare (PHC) services are essential parts of most country's health system which play a vital role in achieving universal health coverage [5]. The provision of health services using a primary healthcare (PHC) model is achieved by meeting people basic health needs in their immediate locality [6]. The goal is to provide quality health, equality in the distribution of services and meeting all the needs of people to achieve optimal treatment outcomes [7]. Some of the healthcare services that fall under this category are promotion, prevention, rehabilitation, and supportive care [4]. To stay healthy and avoid sickness, PHC also includes regular health checkups and health advice for people who are sick and need help with more treatment [8]. The PHC strategy has been shown to lower hospital admissions, healthcare costs, and help communities grow [9]. A well-functioning primary health care system can stop and treat up to 75% of our illnesses [35]. PHCs' rehabilitation programs help people with a range of medical conditions by improving their ability, functioning, and environment which encourages community involvement and well-being [10]. PHC provides palliative care to patients with life-threatening diseases with some support to their caregivers [11]. It also offers total care to people of all ages suffering from terminal diseases, in order to improve the quality of life and reduce suffering for the patient, caregivers and the family [12]. Preventive primary health care services which include illness prevention, health education and health promotion have helped patients with chronic health conditions to live quality life [13]. There are several health disciplines working in the community to provide health services. These include family physicians (FP), public health physicians, general practitioners (GP), nurses and midwives, pharmacy or pharmacy technicians, laboratory technicians, community health extension

workers (CHEWs) and voluntary health workers. A variety of medical specialists, traditional (birth attendants and bone setters), alternative (patent medicine vendors) and allied health professionals (physiotherapists and social workers) may also be present. Generally, there is no restriction on who can participate in PHC [14,15]. The official structure of the PHC system is classified into five levels of healthcare workers depending on their extent of training and qualification [14]. Based on the Primary healthcare structure, medical officers are responsible for managing facilities in the local government by overseeing clinical work and administering many clinical centres [14]. These officers ensure that all the regulatory clinical requirements are met. The Nurse or community health extension officer is the next line manager of primary healthcare center respectively in a situation where there is no medical officer [14,15]. Bringing up the rear are the Community Health Extension Workers (CHEWs) trained from the School of Health Technology for 3 years and qualified with a diploma in community health care and the volunteer health workers (VHWs), including previously trained facility engaged staff to support PHC centers with community case finding and outreach such as traditional birth attendants (TBAs) [14]. To achieve universal health coverage for all, the method used to finance health care system is a vital component in attaining quality health for all [16]. The affordability of the different healthcare services by the people that need it, is dependent on this method of financing [17]. The healthcare systems of most developing countries around the world such as Nigeria are face with many recurrent issues like poor funding, corruption and squandering of resources leading to poor project implementation [18]. In Nigeria, revenue for financing the health sector is collected majorly from pooled and unpooled sources [16]. It notes that health care in Nigeria is financed through different sources including but not limited to tax revenue, out-of-pocket payments (OOPs), donor funding, and health insurance (social and community) [17]. Nigeria, Africa's most populous country, has one of the highest rates of out-of-pocket spending (75%) and one of the lowest rates of health insurance coverage (4%) [19]. This, coupled with a fragmented and poorly resourced primary healthcare system, makes accessing even basic care an insurmountable challenge for most Nigerians [19]. Primary health care is the foundation of healthcare delivery and is key to

the achievement of universal health coverage (UHC) [20]. In 2014, as part of the National Health Act, the Basic Health Care Provision Fund was born [19]. The Basic Health Care Provision Fund (BHCPF) is a direct financial investment that funds Primary Healthcare (PHC) to improve the quality of services [21]. The BHCPF serves to fund a Basic Minimum Package of Health Services (BMPHS), increase the fiscal space for health, strengthen the national health system particularly at primary health care (PHC) level by making provision for routine daily operation cost of PHCs, and ensure access to health care for all, particularly the poor, thus contributing to overall national productivity [22]. A health system of all people, institutions, resources and activities whose primary purpose is to promote, restore and maintain health [23]. Health systems strengthening (HSS) includes the strategies, responses and activities that are designed to sustainably improve the performance of a country's health system [23]. Health systems' strengthening is an integrated and holistic process that ensures optimal performance of healthcare systems in meeting the health needs of the people [24]. Investing now to strengthen health systems is a strategic imperative because a strong health system is the best insurance developing countries can have against a disease burden, or an outbreak that is rapidly unpredictable [24]. Strengthening health systems is critical for achieving universal health coverage in Nigeria and globally [25]. To achieve universal health coverage, health system strengthening (HSS) is required to support the delivery of high-quality care [26]. Health systems' strengthening is aimed at improving and equipping health systems to optimally deliver [24]. Under the Drug Revolving Fund (DRF) scheme, the money received from the sale of medications to patients is used to buy new medications and guarantee a system that is effective, efficient, and available [27]. It involves procuring an initial stock of essential medicines with a seed fund (investment) and availing the patients an opportunity to buy at affordable prices after adding a mark-up for cost recovery. The goal is to ensure sustainability in the availability, accessibility, and affordability of commodities at the health facilities, and minimize the rate of reliance on external funding [28]. The Bamako initiative in 1987 led to the establishment of the national DRF scheme by the government of Nigeria in 1988 with the aim of making essential medicines more available [27,28]. Agencies like the World Health Organization (WHO),

United Nations Children's Fund (UNICEF), and United Kingdom Department for International Development (DFID) provided the government with financial and technical support upon adoption of the DRF scheme; the government believed that the initiative would provide an opportunity to create a sustainable healthcare service delivery at the local level [27]. The state level DRF committee is a body that formulates policies and provides guidance on state-wide implementation of DRF. The structure of the state level committee is designed such that the Director of Pharmaceutical Services acts as the secretary, the Commissioner for Health acts as the Chairperson while the head of all the agencies under the ministry of health are members of the committee.

DISCUSSION

Implementation of DRF Strategy at Primary Health Care System.

In line with the Bamako initiative, the DRF implementation guideline directs that adequate seed fund is allocated to the public healthcare facility from funding sources to carry out bulk procurement of the initial stock of essential drugs and non-drug commodities at a subsidized rate; the public healthcare facility adds a little mark-up to recover cost and sell to patients a cost typically lower than market price, then the revenue generated is used to procure more commodities [29]. Aside allocation of seed funds to public hospitals, the operational guideline for DRF recommends that healthcare providers must be trained to operate the scheme, creating a DRF committee that has clinician and pharmacy personnel with the head of the pharmacy unit being a signatory to the DRF account and following the cost-recovery policy judiciously to protect the integrity of the DRF [30]. Although, drug revolving policy has over time resulted in essential medicine security as compared to the era without the DRF policy [27] and there is evidence that the correct implementation of DRF has led to increased drug availability as well as increased patient visits in government facilities in Kenya [31], and in a tertiary hospital in Nigeria (Shiner, 2023), the DRF scheme across the Primary, Secondary and Tertiary healthcare in Nigeria is faced with sustainability challenges. Some of these challenges include inadequate management of DRF by hospital management, poor accountability, exhaustion and fund diversion, political encroachment, and intentional

stoppage of supply by vendors due to unsettled debts [30]

Since the primary healthcare was handed over to the local government without adequately providing technical support and manpower, [32] the DRF can provide additional resources that can be used to provide cost-effective essential drugs in situations where there is inadequate funds [27]. To achieve the public health goal, through the DRF scheme, there is a need for implementers to have a clear communication system with the public, develop commodity pricing, develop a standardized implementation plan and policies for finance management and monitoring. Another way to improve DRF implementation at PHC is to involve the community and allow the DRF committee to manage available resources locally, decentralizing services [27].

Community Administrative Structures (CAS) in Nigeria (Village/Ward Development Committee [VDC and WDC])

The VDC and WDC form the management structure of the Ward Health system. WDC at the ward level and VDC at the village level within urban and rural settings. The administrative structure for the WDC has all chairmen from the VDC in that ward. These chairmen of VDCs represent their respective VDCs and report health facility problems beyond their capacity to the WDC. WDC serves as the key body for developmental activities carried out within communities in the ward. It is also the apex body for the functions of the Primary health center. Problems at the ward level escalate to the Local Government level. The WDC comprises of; Ward head/the most respected village head, a chairman representing each of the Village Development Committee (VDC) in that ward, WDC elected Chairman and Secretary, the Councilor representing the ward at the LG council, Ward PHC focal person, Community CHIPs engagement person, Members of health-related sectors. The WDC shall have at least 30% women membership [33]. A VDC comprises of; a patron (Village head), Chairman elected by members of the VDC (Must be a respected person), Secretary (elected literate individual), Religious groups representative, women's groups/ associations Representative, Professionals/occupational group representative, NGOs representative, Health facility in-charge, CHIP agents' representative, Persons living with disability representative, Youth

representative, Traditional healers' representative, Patent Medicine vendors' representatives, a treasurer [33].

Incorporating Community Administrative Structure as a PHC-DRF Management Team

Considering the important role of community participation, the National Primary Health Care Development Agency (NPHCDA), introduced the Ward Development Committee (WDC) as a structure trained to represent the people in managing and supporting the development of the PHC without political considerations [34].

The WDC coordinates the steps needed to mobilize human and material resources and finances in the community to support the PHC. The overall service quality improvement can easily be achieved with the community getting involved and taking ownership of the PHC. However, the lack of a functional WDC system in most Nigerian communities has negatively impacted the functioning of PHC as a result of poor community involvement [34]. A study conducted by Oko et al., to evaluate the readiness of WDC to facilitate universal health coverage in Ebonyi state revealed that only a few WDCs still exist in the study area. It also commented that the various committees set up to support PHC across the country are no longer functional due to a lack of support and motivation from the community. Some of the factors that impacted the effectiveness and motivation of the WDC include poor understanding of their functions, lack of incentives, imbalanced composition of the WDC, poor understanding of WDC role by healthcare facility staff, and antagonistic attitude of healthcare facility staff towards members of the WDC [34].

Since a well-implemented DRF can boost the availability of essential medicines and improve service delivery at the health care facility [27,29], and the WDC operation was designed such that members of the committee are not entitled to salary, it is essential to come up with a locally developed, realistic modality to stimulate motivation in WDC system which will strengthen health system and drive sustainability [34]. In this context, it is imperative for the Nigerian government, in collaboration with potential funders, to focus their efforts on implementing DRF as a strategic approach to health financing in primary health centers across Nigeria. Additionally, the revitalization work plan of WDC should be executed in tandem with the DRF to enhance planning, monitoring, and accountability

mechanisms. This dual implementation is ultimately aimed at advancing towards the attainment of universal health coverage.

CONCLUSION

Strengthening the Ward or Villager Development Committee within Nigerian communities can impact the formidability of the primary healthcare system in providing quality and affordable healthcare services. The drug revolving fund implementation, when done with a functional and competent community administrative structure like the VDC or WDC, there will be better DRF monitoring and accountability which will enable the health system to flourish and achieve the goal of universal health coverage.

RECOMMENDATION

Considering how essential it is to have steady access to essential medicines at the primary health centers within communities in Nigeria, the following recommendations should be considered.

1. Establishment of a functional WDC/VDC in all village/ward
2. The creation of an operational DRF committee at each healthcare facility to ensure efficient and transparent money management in conjunction with a capable and operational community administrative structure, such as the VDC or WDC
3. The government ought to provide funding for PHC with an efficient and capable administrative framework
4. National government or State government should establish a drug and medical commodities management agency for easy procurement and distribution.
5. The state government should establish a health insurance organisation and enrol all the PHC
6. Provision of adequate training, monitoring and supportive supervision for the DRF committee and the whole processes

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Conceptualization, OAA, MHS.; Literature review: All authors; Writing –Original Draft: All authors; Final Review & Editing: OAA.

CONFLICT OF INTEREST

The authors alone are responsible for the content of this research and report no conflict of interest.

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